and a shortening of a thigh of 2½ inches after four weeks.

As a rule I prefer to operate when the fracture is several days' old—a week or so—and for the following reasons: there is less swelling, less hemorrhage in the operation, less tissue present of doubtful vitality; healing has already begun, granulation cells or round celled infiltration have begun to form in the part by which the danger of infection is greatly lessened; or as an old time practitioner put it "The cells of healing are in the part"; there is time for the healing of abrasions to have occurred; delirium tremens is apt to have been overcome and there is nothing lost either in mechanical conditions looking to the adjustment of the fragments nor in the time of recovery of the patient.

Dr. Rixford exhibited a number of radiographs of fractures of the leg, thigh and arm adjusted through the open incision and held by wires and staples. As an example of the kind of case which is every now and then put up to the surgeon he showed a plate of a humerus fractured in two places 2½ inches apart; the uppermost fragment shattered, and the lowest split into the elbow joint. The uppermost fragment had penetrated the skin and had cut off the ulnar nerve. The condition present was that of non-union of the lower of the two principal fractures, anchylosis of the elbow and complete muscle-spiral paralysis. Operation showed the nerve ends separated about three inches—stretching gained about three-fourths of an inch. Since the restoration of nerve function is paramount and nerves recover much more completely when the freshened ends are in complete contact, it seems best to shorten the humerus 2½ inches or enough to permit of approximation of the trimmed nerve ends without tension. At date of publication (after four weeks) excellent union of the bone has occurred.

Dr. Harry M. Sherman: I think that we ought to emphasize the point made by Dr. Hunkin about the intra bone splint being merely a coaptation suture. What he has said, too, about the inadequacy of splints we all see, especially in cases from the country, plaster of paris being rarely used for these purposes, and even then often inadequately. I believe that all the different methods of holding the bone by the inside splint, the coaptation suture which has been spoken of, should all be at hand when we operate. I always like to have an X-ray picture taken before the operation but I think that each one will agree that when we open a limb we find that the X-ray picture has only told part of the truth, even although taken in two planes, we often will find the uncovered bone shows conditions not represented in the radiograms as Dr. Stillman has found, that in one case we can use one thing and in the other case another, and we have to be familiar with all the methods and to have them at hand. The retention of these things in the leg afterwards, I think, depends entirely upon sepsis and asepsis. I think that something that I learned from Dr. Hunkin is applicable, that is with regard to too much handling of these things which go into the wound to remain. First they are handled by the operation nurses in laying them out on the instrument table and again by the nurse in handing them to you, by your own assistant and by yourself. The things which go into the limbs should never be touched by anybody but the operator himself, he should take them up and put them into the limb, that is what Dr. Hunkin began doing when he began to put in silk sutures in paralytic limbs. There is altogether too much general handling of instruments in our operating rooms. If we can succeed in getting through an operation practically with asepsis (no operation is absolutely so), only such infections going in as can be taken care of by the blood and tissues, almost any substance and any amount will stay. The transitory nature of this work is something we will all agree to. We have had to take out these staples in some instances and they always come out easily if one pulls them in the direction in which the points lie. I have always used screws, wire and staples except in one instance. In this man (exhibiting radiogram) whose femur was broken just above the condyles in a region where cancellous tissue made it impossible to use a screw or staple efficiently, I put on a wide band reaching from one fragment to the other like a ferrule. The fracture was already an old one when this was done, some callus had been thrown out and this had to be included in the band of ferrule. The band has, however, remained perfectly well in place, holding the alignment accurately; nor does it in any way interfere with function even although it is somewhat near the joint, and much of the callus has disappeared.

Dr. Huntington: I am much pleased at the interest elicited by this subject during the past three years. A comparatively short time has elapsed since frequent resort to the open method in fracture treatment has been seriously entertained. During a recent eastern trip, I was surprised to find how few hospital surgeons manifested a willingness to undertake this line of work. Urgent cases were operated upon without protest, but the idea of approximate reposition seemed to meet the ideals of most surgeons. The question has been asked many times by physicians remote from hospital facilities whether or not they should operate in obdurate cases. The answer is certainly NO.

There is always the alternative of sending such patients to a well equipped hospital, or if that be impossible, the surgeon should protect himself by making a plain statement to the effect that without an operation, a satisfactory result cannot be assured. With a written record of that, the surgeon is safe from subsequent attack. With regard to open fractures, my feeling is that there should be sufficient delay to warrant the presumption that the danger of sepsis is past. We must consider open fractures always as primarily infected and to introduce a new element in the shape of a foreign body under these circumstances is of questionable propriety.

MEDICAL ETHICS IN SAN FRANCISCO.

By W. S. THORNE, M. D., San Francisco.

The following article is a reprint, the original appearing seventeen years ago.

In view of the fact that the subject is one to which attention is constantly drawn by real or fancied transgression of ethical conduct, I venture to hope that the suggestions may not be inappropriate to the present day:

"In California, isolated from the older and more stable societies, the medical profession is characterized by an absence of that *l'esprit de corps* that we observe elsewhere. The explanation of the fact is to be found in the heterogeneous elements comprising the body of the medical profession. The transplanting of men, representing different nationalities, ideals and social conditions, and the consequences that follow the self-restraint and respect imposed upon the individual by the conventionalities of more ancient and crystallized societies, conduce to a diversity of thought and action which we are accustomed to witness here. Provincialism finds expression in self-laudation and an exaggerated idea of the especial superiority of country, educational advantage, and college degree. Nothing so pre-

eminently distinguishes the *small* man—the man whose knowledge of the great world is limited to the confines of his college *campus,* and the geographical boundaries of his native province, as his fancied superiority, and the assumption of great wisdom. Newly released from the pressure and restraint of strict social order, and graded rank, the stranger is prone to regard with ill-suppressed disdain an approach to professional equality with his brethren here. *His* country, *his* attainments, *his* traditions, have deeply impressed *him,* and it is only later that he comes to learn, that schools do not make doctors, and that doctors do not make men—that behind the doctor is the *man* and his *character,* which together comprise all that *he is,* and all that he is *worth* to the community in which he lives. The doctor, whatever his attainments, who is dishonorable, and unethical, who maligns his neighbor, who detracts from honest and conscientious effort on the part of an humble confrere, is a contemptible man. The man of many degrees, the man of encyclopediac knowledge may be, and often is, a weak and incompetent practitioner. Colleges may confer degrees, but they do not confer courage, honor and common sense. Men equally educated differ in point of intelligent application of their acquirements. Men unequally educated will yet more widely differ in this regard, but honest and conscientious effort, however ill-directed, is entitled to respectful consideration. Fortuitous circumstances of birth, educational advantages and natural adaptation, place us individually on different planes, but this difference in potential capacity, if supplemented by honest endeavors, should not detract from the respect due to such attributes. The too frequent tendency in San Francisco to utterly ignore the rules of ethical conduct and for one medical neighbor to openly charge another with ignorance or incompetence, is ignoble. The man who indulges in this sort of egotism, is handling a boomerang, quite as likely to injure the wielder as to destroy the object of its aim. In any event, it lessens confidence and respect of the public for the medical profession. The medical function is nothing, if not dignified and respectful. Pope, cardinal, bishop and priest may serve at the same altar. All men can not stand upon the same level, but erudition and superior station should not dull our sense of justice and fair dealing toward the less fortunate. He who imagines himself pregnant with great wisdom should reach the goal of his ambition without injury to the reputation of his neighbor, and without slurring and injurious comment. Let us be *men,* ready at all times to answer for our words and our actions, considerate of the faults and the mistakes of others. No man can rise or has ever risen to an exalted height in medicine who has not carried with him the love and respect of his contemporaries."

SOCIETY REPORTS

RIVERSIDE COUNTY.

The last meeting of the Riverside County Medical Society for the year prior to the summer vacation was held Monday evening, June 13th, at the Hotel Glenwood. The members of the Society entertained their wives, Senator Miguel Estudillo of Riverside, and Honorable George Freeman of Corona, candidate for the Assembly before the Republican Primaries. Senator Estudillo and Mr. Freeman spoke on the subject of "Medical Legislation." Dr. C. Van Zwaluenburg read a paper on "A Model Practice Act."

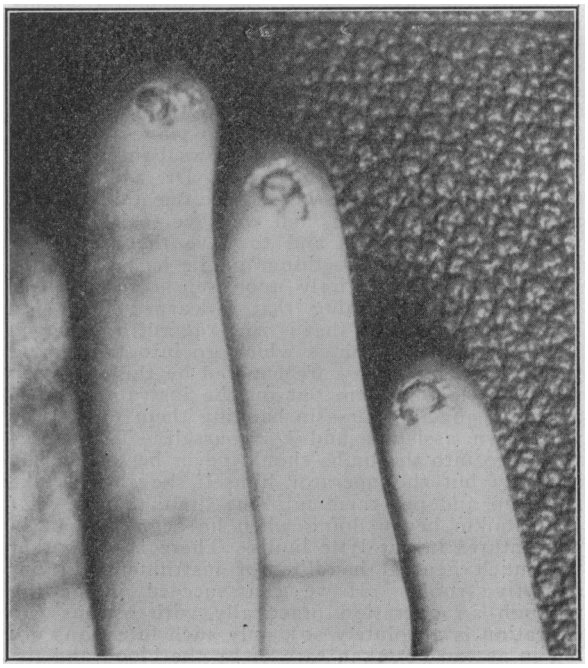
Dr. R. E. Moss of Riverside was elected to membership in the Society.

SAN FRANCISCO COUNTY MEDICAL SOCIETY.

Regular meeting, March 8, 1910.

Dr. H. A. L. Ryfkogel, presenting Case of Tubercular Dactylitis.

Patient, white married woman, 35 years of age, gives no personal or family history of tuberculosis or syphilis. There are no points in the family history that have any bearing on her present condition. Last April she noticed a curious tingling sensation in the left forefinger, which in a few weeks became swollen, and a little later on pus issued from beneath the matrix of the nail. Two or three weeks after this her thumb began to swell and within a couple of months the condition became as you see it now. Examinations of the patient's general physical condition show no disease of any important organ. The radial artery of the diseased side is absent or obliterated. Pulsation of the right radial is normal. Circulation of both hands seems otherwise normal. Examination shows, on the palmar surfaces of the distal phalanges of the third, fourth and fifth fingers, warty growths (see illustration) which rest in sharply punched out excavations. The walls of these snugly grasp the warts. A small amount of pus exudes from between the warts and the walls of the cavities. The second (index finger) is swollen in its distal third and thin pus can be squeezed from beneath the nail matrix. When the



Tubercular Dactylitis.